CRDAMC MEDICAL LIBRARY REGISTRATION Date_____

Name:_____

Rank/Grade:_____Job Title:_____

ETS, PCS or Rotation date:_____

LAST FOUR OF SOCIAL SECURITY NUMBER:_____

Work Information:

Program:_____

OR

Department:_____

Building #:_____

Phone #:_____

Home Address:

Street:_____Apt:_____

City:_____ST:_____Zip:_____

Phone#:_____Email _____

Please ensure all information is correct and that you have included the last four numbers of your SSN.

Individual will be held liable for all books checked out and all signed hand receipts_____ (please initial)

Information provided is protected under 5 U.S.C.552a (b) of the Privacy Act, 1974

(Form approved by the Director of the Medical Library, Carl R. Darnall Army Medical Center Medical Library 2006)